Public Employees Benefits Board (PEBB)

2004 Retiree Medical and Dental Coverage

A

- **List all eligible family members you wish to enroll on this form.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- Dependents must be enrolled in the same plans as the retiree, except as specified for Medicare Supplement Plans E and J.

Retirement system name	PERS 1
Retirement date (mm/dd/yyyy)	

For K-12 school district retirees only:	School district	When does your current school district medical/dental coverage end? (mm/dd/yyyy)

Section 1: Retiree Information

Social security number	Last name	First name	Middle Initial	Sex ☐ M ☐ F

Address	Apt./Unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)

The medical plans marked with an asterisk* in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for the code.**

Physician name or clinic code

Medical Coverage
- ☐ Enroll
- ☐ Defer (due to enrollment in employer coverage)
- ☐ Defer (due to enrollment in a federal retiree program)
- ☐ Terminate: I understand that I am forfeiting all further rights to enroll in the PEBB program.

If deferring, see Section 9.
Note: This defers coverage for all family members.

When do you want coverage to end? Date _____

Are you enrolled in both Parts A and B of Medicare? ☐ Yes ☐ No **Are you receiving Medicare disability?** ☐ Yes ☐ No

Section 2: Spouse or Same-Sex Domestic Partner

*List **only** family members you wish to cover; family members cannot be enrolled in any other PEBB coverage.*

Relationship to Subscriber If adding a spouse or partner, please attach a completed *Declaration of Marriage or Same-Sex Domestic Partnership* form.

Social security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	Physician name or clinic code (contact plan for code)

Medical Coverage ☐ Enroll ☐ Defer ☐ Terminate

If deferring, see Section 9.

Reason: ☐ Widowed ☐ Divorce ☐ Dissolution of same-sex domestic partnership Date of event: _____

Are you enrolled in both Parts A and B of Medicare? ☐ Yes ☐ No **Are you receiving Medicare disability?** ☐ Yes ☐ No

Section 3: Family member information (such as a child, grandchild, etc.) *Use additional forms for more members.*

1

Relationship	Last name	First Name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ☐ M ☐ F	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Physician or clinic code

Address (if different from subscriber)	City	State	ZIP Code

Medical Coverage ☐ Enroll ☐ Defer ☐ Terminate

If deferring, see Section 9.

Reason: _____ Date of event: _____

Are you enrolled in both Parts A and B of Medicare? ☐ Yes ☐ No **Are you receiving Medicare disability?** ☐ Yes ☐ No

2

Relationship	Last name	First Name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ☐ M ☐ F	☐ Disabled? ☐ Student? *Check only if age 20 or older.*	Physician or clinic code

Address (if different from subscriber)	City	State	ZIP Code

Medical Coverage ☐ Enroll ☐ Defer ☐ Terminate

If deferring, see Section 9.

Reason: _____ Date of event: _____

Are you enrolled in both Parts A and B of Medicare? ☐ Yes ☐ No **Are you receiving Medicare disability?** ☐ Yes ☐ No

Section 4: Additions or Changes *Check all that apply.*

Retiree changed: ☐ Name ☐ Address ☐ Medical plan ☐ Dental plan

Change in family status:

☐ **Adding a spouse or same-sex domestic partner**
You **must** complete a Declaration, available from the Health Care Authority or online at **www.pebb.hca.wa.gov**

☐ **Adding family member 1** (from Section 3)

☐ **Adding family member 2** (from Section 3)

Section 5: Medical Plan Selection *Check only one.*

☐ Community Health Plan of Washington*
☐ Group Health Cooperative*
☐ Group Health Options, Inc.*
☐ Kaiser Foundation Health Plan of the Northwest
☐ PacifiCare of Washington, Inc.*
☐ RegenceCare*
☐ Uniform Medical Plan Preferred Provider Organization
☐ Medicare Supplement Plan E, administered by Premera Blue Cross
☐ Medicare Supplement Plan J, administered by Premera Blue Cross

** These plans require the physician or clinic code of your selected primary care provider.* ***Contact your plan or go to the Provider Directory on our Web site for the code.***

Section 6: Dental Plan Selection *Check only one.*

Preferred Provider Organization

☐ Uniform Dental Plan (Group #3000)
(may receive services from any provider)

Managed Care Plans

☐ DeltaCare (Group #3100)
Dentist name or clinic code _____
(must receive services from *DeltaCare provider*)

☐ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

☐ **Cancel Dental**
I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB dental plan for at least two years or I am now covered under employer-sponsored dental. If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

Washington State Health Care Authority
Public Employees Benefits Board

Return form to:

Washington State Health Care Authority
P.O. Box 42684, Olympia, WA 98504-2684

Be sure to sign and date this form.

Note: If you or your dependents are entitled to Medicare, you must be enrolled in **Medicare Parts A and B**. If you haven't sent in a copy of your Medicare card(s), please send a copy of it along with this form.

Visit our Web site at www.pebb.hca.wa.gov

Section 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB life insurance as an active employee. Application for Retiree Term Life Insurance must be made at the time of retirement.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan.
☐ **Yes** ☐ **No**

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Insurance in Force at Time of Death
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

Beneficiary _____

Beneficiary's SSN _____ Relationship to retiree _____

Address _____

_____

Section 8: Authorization for Enrollment and/or Premium Deduction

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage.

☐ Yes, deduct from my pension
☐ No, send me a bill

Section 9: Signature *(Required)*

By submitting this form, I declare under penalty of perjury, to the best of my knowledge and belief, that my family members and I are eligible for the coverage requested. I understand that if I enroll in dental coverage, I must maintain dental coverage for at least two years. I understand that I may be subject to repayment of any claims paid by my health plan or premiums paid on my behalf if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority to be ineligible for coverage.

If deferring coverage, I certify and understand the following provisions:

If deferring my PEBB coverage due to enrollment in employer-sponsored coverage, I must submit an enrollment form and proof of continuous enrollment in employer-sponsored coverage to HCA within 60 days of the date the other coverage ends to reenroll in PEBB retiree coverage. My surviving dependents must submit an application to defer or enroll in PEBB retiree coverage within 90 days of my death.

If deferring my PEBB coverage due to enrollment in a federal retirement program, my dependents and I may exercise a one-time re-enrollment in the future. To exercise re-enrollment, I or my surviving dependents must submit an enrollment form and proof of continuous enrollment in a federal-sponsored retiree medical plan to HCA during an annual open enrollment or within 60 days of the date the other coverage ends.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Washington State law may require disclosure of any information I submit as public record. The HCA's privacy notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Retiree Signature Retiree must sign original to authorize changes

Date _____